		FOR OHF USE					

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2002
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR LONG-TERM CARE FACILITIES
(FISCAL YEAR 2002)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0012252

Facility Name: Oak Glen Home

Address: 11210 95th Street (Number) Coal Valley (City) 61240-9721 (Zip Code)

County: Rock Island County

Telephone Number: 309-799-3161 **Fax #** 309-799-5904

IDPA ID Number: 36-600-6649-001

Date of Initial License for Current Owners: 9/01/1972

Type of Ownership:

	VOLUNTARY,NON-PROFIT		PROPRIETARY	X	GOVERNMENTAL
	Charitable Corp.		Individual		State
	Trust		Partnership	X	County
IRS Exemption Code			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Sheryl Thomas **Telephone Number:** 309-799-3161

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 12/1/2001 to 11/30/2002 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider
(Signed) _____ (Date)
(Type or Print Name) Trudy Whittington
(Title) Administrator

Paid Preparer
(Signed) _____ See Compilation Page (Date)
(Print Name and Title) Tony Cawiezell, Senior Manager
(Firm Name & Address) McGladrey & Pullen, LLP, 600 35th Avenue Moline, Illinois 61265-6155
(Telephone) 309-762-4040 Fax # 309-762-9925

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/1/2001 Ending: 11/30/2002

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds N/A

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	245	Skilled (SNF)	245	89,425	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	245	TOTALS	245	89,425	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	15,163	1,424	3,065	19,652	8
9	SNF/PED					9
10	ICF	35,389	5,568	0	40,957	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	50,552	6,992	3,065	60,609	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 67.78%

D. How many bed-hold days during this year were paid by Public Aid?
0 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
None

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [ ] NO [X]

I. On what date did you start providing long term care at this location?
Date started 09/01/1972

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date _____ NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 20 and days of care provided 365

Medicare Intermediary Mutual of Omaha

IV. ACCOUNTING BASIS

ACCRUAL [X] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [ ] NO [ ]

Tax Year: N/A Fiscal Year: November 30, 2001

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/1/2001 Ending: 11/30/2002

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	421,563	53,330	17,670	492,563		492,563		492,563			1
2	Food Purchase		344,991		344,991	(524)	344,467		344,467			2
3	Housekeeping	220,859	26,680	6,556	254,095		254,095		254,095			3
4	Laundry	174,654	37,547	1,157	213,358		213,358	(5,148)	208,210			4
5	Heat and Other Utilities			162,694	162,694		162,694		162,694			5
6	Maintenance	184,284	42,485	45,235	272,004		272,004	(26,041)	245,963			6
7	Other (specify):*							(63,446)	(63,446)			7
8	**TOTAL General Services**	1,001,360	505,033	233,312	1,739,705	(524)	1,739,181	(94,635)	1,644,546			8
	B. Health Care and Programs											
9	Medical Director					16,000	16,000		16,000			9
10	Nursing and Medical Records	2,569,910	226,295	73,108	2,869,313	(95,641)	2,773,672	(1,830)	2,771,842			10
10a	Therapy	123,456	1,988	215,761	341,205		341,205		341,205			10a
11	Activities					115,614	115,614		115,614			11
12	Social Services	188,935	7,066	238	196,239	(115,614)	80,625		80,625			12
13	Nurse Aide Training	916		2,200	3,116	900	4,016		4,016			13
14	Program Transportation					1,789	1,789		1,789			14
15	Other (specify):*											15
16	**TOTAL Health Care and Programs**	2,883,217	235,349	291,307	3,409,873	(76,952)	3,332,921	(1,830)	3,331,091			16
	C. General Administration											
17	Administrative					96,625	96,625		96,625			17
18	Directors Fees							7,736	7,736			18
19	Professional Services							218,924	218,924			19
20	Dues, Fees, Subscriptions & Promotions			284	284	38,431	38,715	(36,949)	1,766			20
21	Clerical & General Office Expenses	218,858	5,800	78,178	302,836	(134,532)	168,304		168,304			21
22	Employee Benefits & Payroll Taxes			1,003,188	1,003,188		1,003,188	140,552	1,143,740			22
23	Inservice Training & Education											23
24	Travel and Seminar			7,640	7,640	(1,789)	5,851		5,851			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice											26
27	Other (specify):*											27
28	**TOTAL General Administration**	218,858	5,800	1,089,290	1,313,948	(1,265)	1,312,683	330,263	1,642,946			28
29	**TOTAL Operating Expense (sum of lines 8, 16 & 28)**	4,103,435	746,182	1,613,909	6,463,526	(78,741)	6,384,785	233,798	6,618,583			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Oak Glen Home #0012252 Report Period Beginning: 12/1/2001 Ending: 11/30/2002

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage 1	Supplies 2	Other 3	Total 4	5	6	7	8	9	10	
	D. Ownership											
30	Depreciation							123,560	123,560			30
31	Amortization of Pre-Op. & Org.											31
32	Interest							18,157	18,157			32
33	Real Estate Taxes											33
34	Rent-Facility & Grounds							8,749	8,749			34
35	Rent-Equipment & Vehicles			21,428	21,428		21,428	(21,301)	127			35
36	Other (specify):*			70,634	70,634		70,634	(175)	70,459			36
37	**TOTAL Ownership**			92,062	92,062		92,062	128,990	221,052			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers					78,741	78,741		78,741			39
40	Barber and Beauty Shops											40
41	Coffee and Gift Shops											41
42	Provider Participation Fee							134,138	134,138			42
43	Other (specify):*											43
44	**TOTAL Special Cost Centers**					78,741	78,741	134,138	212,879			44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	4,103,435	746,182	1,705,971	6,555,588		6,555,588	496,926	7,052,514			45

***Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.**

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/1/2001 Ending: 11/30/2002

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals				4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation				9
10	Interest and Other Investment Income	18,157	32		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties				18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(36,949)	20		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising				28
29	Other-Attach Schedule	(120,510)	MISC		29
30	**SUBTOTAL (A): (Sum of lines 1-29)**	$ (139,302)		$	30

OHF USE ONLY								
48		49		50		51		52	

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*	2,442	6	32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule	260,025		35
36	**SUBTOTAL (B): (sum of lines 31-35)**	$ 262,467		36
37	**TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))**	$ 123,165		37

***These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.**

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.	Yes	No	$		38
39			N			39
40	Gift and Coffee Shops		N			40
41	Barber and Beauty Shops		N			41
42	Laboratory and Radiology		N			42
43	Prescription Drugs		N			43
44	Exceptional Care Program		N			44
45	Other-Attach Schedule		N			45
46	Other-Attach Schedule		N			46
47	**TOTAL (C): (sum of lines 38-46)**			$		47

Oak Glen Home

ID# 0012252

Report Period Beginning: 12/1/2001

Ending: 11/30/2002

	NON-ALLOWABLE EXPENSES	Amount	Sch. V Line Reference	
1	BARBER & BEAUTY INCOME	$ (1,830)	10	1
2	OFFICE EQUIPMENT RENTAL INCOME	(21,301)	35	2
3	NON-MEDICALLY NECESSARY TRANSPOR	(3,150)	6	3
4	CAPITAL ITEMS	(63,446)	7	4
5	TRANSPORTATION REVENUE	(296)	6	5
6	RENT REVENUE	(25,037)	6	6
7	LAUNDRY REVENUE	(5,148)	4	7
8	SALES OF JUNK OR SALVAGE	(175)	36	8
9				9
10				10
11				11
12				12
13				13
14				14
15				15
16				16
17				17
18				18
19				19
20				20
21				21
22				22
23				23
24				24
25				25
26				26
27				27
28				28
29				29
30				30
31				31
32				32
33				33
34				34
35				35
36				36
37				37
38				38
39				39
40				40
41				41
42				42
43				43
44				44
45				45
46				46
47				47
48				48
49	**Total**	(120,383)		49

STATE OF ILLINOIS

Summary A

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/1/2001 Ending: 11/30/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Operating Expenses	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
	A. General Services													
1	Dietary	0	0	0	0	0	0	0	0	0	0	0	0	1
2	Food Purchase	0	0	0	0	0	0	0	0	0	0	0	0	2
3	Housekeeping	0	0	0	0	0	0	0	0	0	0	0	0	3
4	Laundry	(5,148)	0	0	0	0	0	0	0	0	0	0	(5,148)	4
5	Heat and Other Utilities	0	0	0	0	0	0	0	0	0	0	0	0	5
6	Maintenance	(26,041)	0	0	0	0	0	0	0	0	0	0	(26,041)	6
7	Other (specify):*	(63,446)	0	0	0	0	0	0	0	0	0	0	(63,446)	7
8	**TOTAL General Services**	(94,635)	0	0	0	0	0	0	0	0	0	0	(94,635)	8
	B. Health Care and Programs													
9	Medical Director	0	0	0	0	0	0	0	0	0	0	0	0	9
10	Nursing and Medical Records	(1,830)	0	0	0	0	0	0	0	0	0	0	(1,830)	10
10a	Therapy	0	0	0	0	0	0	0	0	0	0	0	0	10a
11	Activities	0	0	0	0	0	0	0	0	0	0	0	0	11
12	Social Services	0	0	0	0	0	0	0	0	0	0	0	0	12
13	Nurse Aide Training	0	0	0	0	0	0	0	0	0	0	0	0	13
14	Program Transportation	0	0	0	0	0	0	0	0	0	0	0	0	14
15	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	15
16	**TOTAL Health Care and Programs**	(1,830)	0	0	0	0	0	0	0	0	0	0	(1,830)	16
	C. General Administration													
17	Administrative	0	0	0	0	0	0	0	0	0	0	0	0	17
18	Directors Fees	0	7,736	0	0	0	0	0	0	0	0	0	7,736	18
19	Professional Services	0	218,924	0	0	0	0	0	0	0	0	0	218,924	19
20	Fees, Subscriptions & Promotions	(36,949)	0	0	0	0	0	0	0	0	0	0	(36,949)	20
21	Clerical & General Office Expenses	0	0	0	0	0	0	0	0	0	0	0	0	21
22	Employee Benefits & Payroll Taxes	0	140,552	0	0	0	0	0	0	0	0	0	140,552	22
23	Inservice Training & Education	0	0	0	0	0	0	0	0	0	0	0	0	23
24	Travel and Seminar	0	0	0	0	0	0	0	0	0	0	0	0	24
25	Other Admin. Staff Transportation	0	0	0	0	0	0	0	0	0	0	0	0	25
26	Insurance-Prop.Liab.Malpractice	0	0	0	0	0	0	0	0	0	0	0	0	26
27	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	27
28	**TOTAL General Administration**	(36,949)	367,212	0	0	0	0	0	0	0	0	0	330,263	28
29	**TOTAL Operating Expense (sum of lines 8,16 & 28)**	(133,414)	367,212	0	0	0	0	0	0	0	0	0	233,798	29

STATE OF ILLINOIS

Summary B

Facility Name & ID Number Oak Glen Home # 0012252 **Report Period Beginning:** 12/1/2001 **Ending:** 11/30/2002

SUMMARY OF PAGES 5, 5A, 6, 6A, 6B, 6C, 6D, 6E, 6F, 6G, 6H AND 6I

	Capital Expense D. Ownership	PAGES 5 & 5A	PAGE 6	PAGE 6A	PAGE 6B	PAGE 6C	PAGE 6D	PAGE 6E	PAGE 6F	PAGE 6G	PAGE 6H	PAGE 6I	SUMMARY TOTALS (to Sch V, col.7)	
30	Depreciation	0	0	0	0	0	0	0	0	0	0	0	0	30
31	Amortization of Pre-Op. & Org.	0	0	0	0	0	0	0	0	0	0	0	0	31
32	Interest	18,157	0	0	0	0	0	0	0	0	0	0	18,157	32
33	Real Estate Taxes	0	0	0	0	0	0	0	0	0	0	0	0	33
34	Rent-Facility & Grounds	0	8,749	0	0	0	0	0	0	0	0	0	8,749	34
35	Rent-Equipment & Vehicles	(21,301)	0	0	0	0	0	0	0	0	0	0	(21,301)	35
36	Other (specify):*	(175)	0	0	0	0	0	0	0	0	0	0	(175)	36
37	**TOTAL Ownership**	(3,319)	8,749	0	0	0	0	0	0	0	0	0	5,430	37
	Ancillary Expense													
	E. Special Cost Centers													
38	Medically Necessary Transportation	0	0	0	0	0	0	0	0	0	0	0	0	38
39	Ancillary Service Centers	0	0	0	0	0	0	0	0	0	0	0	0	39
40	Barber and Beauty Shops	0	0	0	0	0	0	0	0	0	0	0	0	40
41	Coffee and Gift Shops	0	0	0	0	0	0	0	0	0	0	0	0	41
42	Provider Participation Fee	0	0	0	0	0	0	0	0	0	0	0	0	42
43	Other (specify):*	0	0	0	0	0	0	0	0	0	0	0	0	43
44	**TOTAL Special Cost Centers**	0	0	0	0	0	0	0	0	0	0	0	0	44
45	**GRAND TOTAL COST (sum of lines 29, 37 & 44)**	(136,733)	375,961	0	0	0	0	0	0	0	0	0	239,228	45

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/1/2001 Ending: 11/30/2002

VII. RELATED PARTIES

A. **Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.**

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [X] YES [ ] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1	Schedule V	2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V	18	Welfare Committee	$	Rock Island County	100.00%	$ 7,736	$ 7,736	1
2	V	19	Risk Management		Rock Island County	100.00%	58,102	58,102	2
3	V	19	General Management		Rock Island County	100.00%	32,964	32,964	3
4	V	19	Auditor		Rock Island County	100.00%	15,190	15,190	4
5	V	19	Purchasing		Rock Island County	100.00%	1,951	1,951	5
6	V	34	County Buildings		Rock Island County	100.00%	8,749	8,749	6
7	V	19	Information Systems		Rock Island County	100.00%	26,778	26,778	7
8	V	19	Treasurer		Rock Island County	100.00%	12,713	12,713	8
9	V	19	County Board		Rock Island County	100.00%	70,464	70,464	9
10	V	19	States Attor/County Clerk		Rock Island County	100.00%	762	762	10
11	V	26	Property Insurance		Rock Island County	100.00%			11
12	V	22	Worker's Compensation		Rock Island County	100.00%	131,844	131,844	12
13	V	22	Unemployment Compensation		Rock Island County	100.00%	8,708	8,708	13
14	Total			$			$ 375,961	$ * 375,961	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/1/2001 Ending: 11/30/2002

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1	2	3	4	5	6		7		8	
	Name	Title	Function	Ownership Interest	Compensation Received From Other Nursing Homes*	Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		Compensation Included in Costs for this Reporting Period**		Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	Kay Banfield	Chair, Nurs. Home	Director					Portion of Sal	$ 1,027		1
2	Phillip Banaszek	Nurs. Home Commit	Director					Portion of Sal	1,118		2
3	Karen Calvillo	Nurs. Home Commit	Director					Portion of Sal	1,118		3
4	Johnny Ellis	Nurs. Home Commit	Director					Portion of Sal	1,118		4
5	Frank Fuhr	Nurs. Home Commit	Director					Portion of Sal	1,118		5
6	LaVern Ohlsen	Nurs. Home Commit	Director					Portion of Sal	1,118		6
7	Don Verstracte	Nurs. Home Commit	Director					Portion of Sal	1,118		7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$ 7,736		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/1/2001 Ending: 1/30/2002

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [X] NO [ ]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization: Rock Island County
Street Address: 1504 Third Avenue
City / State / Zip Code: Rock Island, IL 61201
Phone Number: (309-786-4451
Fax Number: (309-786-9883

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1	18	Welfare Board		100		$ 7,736	$	100	$ 7,736	1
2	19	Liabililty Claims	Actual Cost	100		0		100	0	2
3	19	Risk Management	Cost Allocation Study	100		193,980		30	58,175	3
4	19	General County	Cost Allocation Study	100		1,601,879		2	32,054	4
5	19	Auditor	Cost Allocation Study	100		172,460		8	13,797	5
6	19	Purchasing	Cost Allocation Study	100		88,755		2	1,775	6
7	19	County Building	Cost Allocation Study	100		824,429		1	8,244	7
8	19	Information Systems	Cost Allocation Study	100		570,118		5	28,506	8
9	19	Treasurer	Cost Allocation Study	100		331,639		4	13,266	9
10	19	County Board	Cost Allocation Study	100		442,994		16	70,879	10
11	21	State's Attorney	Cost Allocation Study	100		1,786,902		0	625	11
12	22	Worker's Compensation	Actual Cost	100		131,844		100	131,844	12
13	22	Unemployment Insurance	Actual Cost	100		8,708		100	8,708	13
14	26	Property Insurance	Actual Cost	100		0		100	0	14
15	21	County Clerk	Cost Allocation Study	100		1,021,399		0	204	15
16	19	Rounding	Cost Allocation Study	100		148		100	148	16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$ 7,182,991	$		$ 375,961	25

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/1/2001 Ending: 11/30/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related											
	Long-Term											
1	Schedule N/A, no loans						$	$			$	1
2												2
3												3
4												4
5												5
	Working Capital											
6												6
7												7
8												8
9	TOTAL Facility Related						$	$			$	9
	B. Non-Facility Related*											
10												10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$	$			$	14
15	TOTALS (line 9+line14)						$	$			$	15

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/1/2001 Ending: 11/30/2002

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

1. Real Estate Tax accrual used on 2001 report.	***Important***, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.	$ Schedule N/A	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)		$	2
3. Under or (over) accrual (line 2 minus line 1).		$ #VALUE!	3
4. Real Estate Tax accrual used for 2002 report. (Detail and explain your calculation of this accrual on the lines below.)		$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. **(Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)**		$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. **TOTAL REFUND $ For 19 Tax Year.** **(Attach a copy of the real estate tax appeal board's decision.)**		$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.		$ #VALUE!	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1996		8
1997		9
1998		10
1999		11
2000		12

FOR OHF USE ONLY

13	FROM R. E. TAX STATEMENT FOR 2001	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. **Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.**
2. **If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.**

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2000 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2000 real estate tax costs, as well as copies of your real estate tax bills for calendar 2000.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2000 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2001 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2000 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Oak Glen Home COUNTY Rock Island County

FACILITY IDPH LICENSE NUMBER 0012252

CONTACT PERSON REGARDING THIS REPORT

TELEPHONE ( ) FAX #: ( )

A. **Summary of Real Estate Tax Cost**

Enter the tax index number and real estate tax assessed for 2000 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2000.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. **Real Estate Tax Cost Allocations**

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? YES NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. **Tax Bills**

Attach a copy of the 2000 tax bills which were listed in Section A to this statement. Be sure to use the 2000 tax bill which is normally paid during 2001.

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/1/2001 Ending: 11/30/2002

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 92,498 B. General Construction Type: Exterior _____ Frame Block & Brick Number of Stories 2

C. Does the Operating Entity? [X] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [X] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

Not Applicable

Note for Section XI below: Land for Oak Glen Home was donated to Rock Island County in the early 1900s. No cost was incurred by the home, nor was any cost assigned by an outside appraisal firm in the 1970s

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [X] NO
If so, please complete the following:

1. Total Amount Incurred: _____ 2. Number of Years Over Which it is Being Amortized: _____

3. Current Period Amortization: _____ 4. Dates Incurred: _____

Nature of Costs: _____
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Operations	280 Acres		$	1
2					2
3	TOTALS	#VALUE!		$	3

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/1/2001 Ending: 11/30/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	245		1954	1954	$ 443,748	$ 8,531		$ 8,531	$	$ 133,605	4
5			1966	1966	3,438					3,438	5
6			1967	1967	601,561	21,435		21,435		142,470	6
7			1969	1969	176,656					176,656	7
8			1972	1972	8,370					8,370	8
	Improvement Type**										
9				1977	68,095					68,095	9
10				1978	101,833					101,833	10
11				1979	2,884					2,884	11
12				1980	5,464					5,464	12
13				1981	2,920					2,920	13
14				1982	40,602	1,871		1,871		40,062	14
15				1983	13,365	244		244		13,253	15
16				1984	209,823	9,556		9,556		157,810	16
17				1985	39,133	1,958		1,958		33,303	17
18				1986	35,460	1,775		1,775		29,239	18
19				1987	36,101	672		672		33,084	19
20				1988	2,590	123		123		1,794	20
21				1989	22,670	907		907		11,864	21
22				1990	17,573	879		879		10,738	22
23				1991	3,100					3,100	23
24				1992	12,281	723		723		8,810	24
25				1993	16,131	807		807		7,803	25
26				1994	32,605	2,503		2,503		20,663	26
27				1995	68,144	3,732		3,732		27,870	27
28				1996	2,620	175		175		1,123	28
29				1997	14,800	740		740		3,959	29
30				1998	110,234	16,194		16,194		61,225	30
31				1999	27,802	3,342		3,342		10,573	31
32				2000	22,972	2,764		2,764		7,206	32
33				2001	4,182	418		418		802	33
34				2002	3,160	52		52		52	34
35											35
36											36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/1/2001 Ending: 11/30/2002

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37			$	$		$	$	$	37
38									38
39									39
40									40
41									41
42									42
43									43
44									44
45									45
46									46
47									47
48									48
49									49
50									50
51									51
52									52
53									53
54									54
55									55
56									56
57									57
58									58
59									59
60									60
61									61
62									62
63									63
64									64
65									65
66									66
67									67
68									68
69									69
70	TOTAL (lines 4 thru 69)		$ 2,150,317	$ 79,401		$ 79,401	$	$ 1,130,068	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/1/2001 Ending: 11/30/2002

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 271,118	$ 24,163	$ 24,163	$		$ 184,205	71
72	Current Year Purchases	49,638	2,149	2,149			2,149	72
73	Fully Depreciated Assets	247,986	807	807			247,986	73
74								74
75	TOTALS	$ 568,742	$ 27,119	$ 27,119	$		$ 434,340	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Care	various	various	$ 178,939	$ 17,040	$ 17,040	$		$ 151,774	76
77										77
78										78
79										79
80	TOTALS			$ 178,939	$ 17,040	$ 17,040	$		$ 151,774	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount		
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,897,998	81	
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 123,560	82	
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 123,560	83	**
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$	84	
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,716,182	85	

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87					87
88					88
89					89
90					90
91	TOTALS	$	$	$	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/1/2001 Ending: 11/30/2002

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease: N/A
2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4? If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Date of Lease	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease ____.

9. Option to Buy: ☐ YES ☐ NO Terms: ____ *

10. Effective dates of current rental agreement:
Beginning ____
Ending ____

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2003	$
13.	/2004	$
14.	/2005	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☐ NO
16. Rental Amount for movable equipment: $ 21,428 Description: ____
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/1/2001 Ending: 11/30/2002

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [X] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
COMMUNITY COLLEGE	
HOURS PER AIDE	80

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	X
IN OTHER FACILITY	
HOURS PER AIDE	40

B. EXPENSES

ALLOCATION OF COSTS (d)

		1	2	3	4
		Facility			
		Drop-outs	Completed	Contract	Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		1,942		1,942
3	Classroom Wages (a)				
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)		1,174		1,174
6	Transportation				
7	Contractual Payments				
8	Nurse Aide Competency Tests		900		900
9	TOTALS	$	$ 4,016	$	$ 4,016
10	SUM OF line 9, col. 1 and 2 (e)	$ 4,016			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	18
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	2
2. From other facilities (f)	
TOTAL TRAINED	20

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/1/2001 Ending: 11/30/2002

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist		hrs	$		$	$		$	1
2	Licensed Speech and Language Development Therapist		hrs							2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist		hrs							4
5	Physician Care		visits							5
6	Dental Care		visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	L39, Col 6	# of prescrpts	78,741					78,741	9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program									12
13	Other (specify):									13
14	TOTAL			$ 78,741		$	$		$ 78,741	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

STATE OF ILLINOIS

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/1/2001 Ending: 11/30/2002

XV. BALANCE SHEET - Unrestricted Operating Fund.

As of 11/30/2002 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 1,972	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	40,503		3
4	Supply Inventory (priced at)			4
5	Short-Term Investments	1,534,627		5
6	Prepaid Insurance			6
7	Other Prepaid Expenses	1,721		7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):	640,128		9
10	**TOTAL Current Assets (sum of lines 1 thru 9)**	$ 2,218,951	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land			13
14	Buildings, at Historical Cost			14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost			16
17	Accumulated Depreciation (book methods)			17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	**TOTAL Long-Term Assets (sum of lines 11 thru 23)**	$	$	24
25	**TOTAL ASSETS (sum of lines 10 and 24)**	$ 2,218,951	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ 184,023	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits	400		28
29	Short-Term Notes Payable			29
30	Accrued Salaries Payable	301,609		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)			32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36	Due other Funds	109,362		36
37				37
38	**TOTAL Current Liabilities (sum of lines 26 thru 37)**	$ 595,394	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable			40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	**TOTAL Long-Term Liabilities (sum of lines 39 thru 44)**	$	$	45
46	**TOTAL LIABILITIES (sum of lines 38 and 45)**	$ 595,394	$	46
47	**TOTAL EQUITY(page 18, line 24)**	$ 1,623,556	$	47
48	**TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)**	$ 2,218,950	$	48

*(See instructions.)

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/1/2001 Ending: 11/30/2002

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	**Balance at Beginning of Year, as Previously Reported**	$ 450,604	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	**Balance at Beginning of Year, as Restated (sum of lines 1-5)**	$ 450,604	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	1,172,952	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe)		15
16	Other (describe)		16
17	**TOTAL Additions (deductions) (sum of lines 7-16)**	$ 1,172,952	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	**TOTAL Transfers (sum of lines 18-22)**	$	23
24	**BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)**	$ 1,623,556	24 *

*** This must agree with page 17, line 47.**

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/1/2001 Ending: 11/30/2002

XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense

	Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 6,047,030	1
2	Discounts and Allowances for all Levels	( )	2
3	**SUBTOTAL Inpatient Care (line 1 minus line 2)**	$ 6,047,030	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy		6
7	Oxygen		7
8	**SUBTOTAL Ancillary Revenue (lines 4 thru 7)**	$	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements	7,850	11
12	Gift and Coffee Shop		12
13	Barber and Beauty Care	1,830	13
14	Non-Patient Meals		14
15	Telephone, Television and Radio		15
16	Rental of Facility Space	44,779	16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients	4,275	18
19	Laboratory		19
20	Radiology and X-Ray		20
21	Other Medical Services	296	21
22	Laundry	5,148	22
23	**SUBTOTAL Other Operating Revenue (lines 9 thru 22)**	$ 64,178	23
	D. Non-Operating Revenue		
24	Contributions		24
25	Interest and Other Investment Income***		25
26	**SUBTOTAL Non-Operating Revenue (lines 24 and 25)**	$ 18,157	26
	E. Other Revenue (specify):**		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Sale of Fixed Asset	175	28
28a	Transfer from other govt. units	1,599,000	28a
29	**SUBTOTAL Other Revenue (lines 27, 28 and 28a)**	$ 1,599,175	29
30	**TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)**	$ 7,728,540	30

	Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	1,739,705	31
32	Health Care	3,409,873	32
33	General Administration	1,313,948	33
	B. Capital Expense		
34	Ownership	92,062	34
	C. Ancillary Expense		
35	Special Cost Centers		35
36	Provider Participation Fee		36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	**TOTAL EXPENSES (sum of lines 31 thru 39)***	$ 6,555,588	40
41	**Income before Income Taxes (line 30 minus line 40)****	1,172,952	41
42	**Income Taxes**		42
43	**NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)**	$ 1,172,952	43

* **This must agree with page 4, line 45, column 4.**

** **Does this agree with taxable income (loss) per Federal Income Tax Return? N/A If not, please attach a reconciliation.**

*** **See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.**

**** **Provide a detailed breakdown of "Other Revenue" on an attached sheet.**

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/1/2001 Ending: 11/30/2002

XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	1,750	2,080	$ 42,658	$ 20.51	1
2	Assistant Director of Nursing	1,556	1,808	34,296	18.97	2
3	Registered Nurses	10,087	10,730	203,554	18.97	3
4	Licensed Practical Nurses	53,220	59,025	854,067	14.47	4
5	Nurse Aides & Orderlies	126,054	138,326	1,405,133	10.16	5
6	Nurse Aide Trainees	513	513	3,053	5.95	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	8,024	9,243	123,180	13.33	8
9	Activity Director	1,866	2,165	35,461	16.38	9
10	Activity Assistants	6,675	7,784	80,153	10.30	10
11	Social Service Workers	5,164	5,811	73,544	12.66	11
12	Dietician					12
13	Food Service Supervisor	3,511	4,168	57,713	13.85	13
14	Head Cook	7,708	8,437	94,726	11.23	14
15	Cook Helpers/Assistants	4,407	5,263	55,115	10.47	15
16	Dishwashers	21,863	23,818	214,258	9.00	16
17	Maintenance Workers	9,900	11,923	184,281	15.46	17
18	Housekeepers	18,155	21,218	220,859	10.41	18
19	Laundry	14,092	16,832	174,659	10.38	19
20	Administrator	1,817	2,088	52,805	25.29	20
21	Assistant Administrator	1,689	2,080	43,819	21.07	21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	8,959	10,192	122,234	11.99	24
25	Vocational Instruction	270	280	5,382	19.22	25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records	1,887	2,114	22,485	10.64	31
32	Other Health Care(specify)					32
33	Other(specify)					33
34	TOTAL (lines 1 - 33)	309,167	345,898	$ 4,103,435 *	$ 11.86	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	496	$ 15,856	L1, C3	35
36	Medical Director	12 months	16,000	L9, C5	36
37	Medical Records Consultant	9	225	L10, C3	37
38	Nurse Consultant				38
39	Pharmacist Consultant	12 months	1,260	L10, C3	39
40	Physical Therapy Consultant	2,118	110,100	L10a, C3	40
41	Occupational Therapy Consultant	1,993	94,068	L10a, C3	41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant	168	22,592	L10a, C3	43
44	Activity Consultant	10	640	L12, C3	44
45	Social Service Consultant				45
46	Other(specify) Lab		6,911	L10, C3	46
47	Radiology		590	L10, C3	47
48	Ortho & Rheumatology		337	L10, C3	48
49	TOTAL (lines 35 - 48)	4,794	$ 268,579		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses		$		50
51	Licensed Practical Nurses				51
52	Nurse Aides	1,425	24,496	L10, C3	52
53	TOTAL (lines 50 - 52)	1,425	$ 24,496		53

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/1/2001 Ending: 11/30/2002

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
Trudy Whittington	Administrator		$ 52,806
Sheryl Thomas	Asst. Administrator		43,819
TOTAL (agree to Schedule V, line 17, col. 1) (List each licensed administrator separately.)			$ 96,625

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3) (Attach a copy of any management service agreement)	$

C. Professional Services

Vendor/Payee	Type	Amount
		$
TOTAL (agree to Schedule V, line 19, column 3) (If total legal fees exceed $2500 attach copy of invoices.)		$

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 131,844
Unemployment Compensation Insurance	8,708
FICA Taxes	304,520
Employee Health Insurance	596,397
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	102,271
TOTAL (agree to Schedule V, line 22, col.8)	$ 1,143,740

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$
Advertising: Employee Recruitment	
Health Care Worker Background Check	
(Indicate # of checks performed 48)	576
Subscription, Dues & Fees	615
NAEIR Dues & Fees	575
	0
Less: Public Relations Expense	( )
Non-allowable advertising	(0)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 1,766

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
In-State Travel	199
Seminar Expense	5,652
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 5,851

* Attach copy of IMRF notifications

**See instructions.

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/1/2001 Ending: 11/30/2002

XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY1998	FY1999	FY2000	FY2001	FY2002	FY2003	FY2004	FY2005	FY2006
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Oak Glen Home # 0012252 Report Period Beginning: 12/1/2001 Ending: 11/30/2002

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? **Yes**

(2) Are there any dues to nursing home associations included on the cost report? **Yes**
If YES, give association name and amount. **County Nursing Home Assoc - $1,580**

(3) Did the nursing home make political contributions or payments to a political action organization? **No** If YES, have these costs been properly adjusted out of the cost report? **N/A**

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? **No** If YES, what is the capacity? **N/A**

(5) Have you properly capitalized all major repairs and equipment purchases? **Yes**
What was the average life used for new equipment added during this period? **8 years**

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ **50,207** Line **10**

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? **Yes** If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement? **No**
If YES, give effective date of lease. **N/A**

(9) Are you presently operating under a sublease agreement? YES **X** NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO **X** If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ **134,138**
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? **No** If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? **Yes**

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? **Yes** For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ **N/A** Has any meal income been offset against related costs? Indicate the amount. $

(16) Travel and Transportation

a. Are there costs included for out-of-state travel? **No**
If YES, attach a complete explanation.

b. Do you have a separate contract with the Department to provide medical transportation for residents? **Yes** If YES, please indicate the amount of income earned from such a program during this reporting period. $ **274**

c. What percent of all travel expense relates to transportation of nurses and patients? **90%**

d. Have vehicle usage logs been maintained? **No**

e. Are all vehicles stored at the nursing home during the night and all other times when not in use? **Yes**

f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? **N/A**

g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $ **N/A**

(17) Has an audit been performed by an independent certified public accounting firm? **Yes**
Firm Name: **McGladrey & Pullen, LLP** The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out of Schedule V? **Yes**

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? **N/A**
Attach invoices and a summary of services for all architect and appraisal fees